EXHIBIT 2

RECEIVED

SEP 16 2003

PLAYER BENEFITS

Bert Bell/Pete Rozelle NFL Player Retirement Plan

Application for Disability Benefits

[Date Mailed to Player]
(FOR PLAN USE ONLY; DO NOT WRITE BELOW)

Mail Completed Form to:

Bert Bell/Pete Rozelle
NFL Player Retirement Plan
200 St. Paul Place, Suite 2420
Baltimore, Maryland 21202-2040
(410) 685-5069 (800) 638-3186

[Date Received]
(FOR PLAN USE ONLY; DO NOT WRITE BELOW)

Instructions

To apply for disability benefits from the Bert Bell/Pete Rozelle NFL Player Retirement Plan ("Plan"), you must complete this application and return it to the Plan Office with all required information. The Plan Office will then advise you whether any further information is required in connection with your application.. Your application will not be considered complete until the Plan Office receives this application with all required information.

In general, the Plan provides total and permanent disability ("T&P") benefits to eligible players who are substantially unable to work, and line-of-duty disability ("LOD") benefits to eligible players who suffer a "substantial disablement." The end of this form contains further information about these benefits.

Player Information

Name Tyrone P. Keys
Date of Birth [redacted]
Social Security No [redacted]
Address (No., Street) [redacted]
Home Phone
City, State, Zip
Office Phone
Marital Status ( ) Single (✓) Married

Benefits Requested

This is an application for (please check one):

( ) Only line-of-duty disability ("LOD") benefits (complete LOD section below)
(✓) Only total and permanent disability ("T&P") benefits (complete T&P section below)
( ) Both LOD and T&P benefits (complete both LOD and T&P sections below)

Line-of-Duty ("LOD") Benefits

To be eligible for LOD benefits, the Plan Office must receive your application within 48 months after you cease to be an Active Player, as defined by the Plan. This 48-month period may be extended if you have been physically or mentally incapacitated in a manner that substantially interfered with your ability to file this claim. If you seek such an exception, or wish to describe when you ceased to be an Active Player, please do so below or on an additional sheet:

Describe the condition or conditions you have that you believe qualify you for LOD benefits:

1. ______
2. ______
3. ______
4. ______

(Attach additional sheet if necessary)

Do you wish to provide additional information in support of your application for LOD benefits?
( ) Yes ( ) No

If you checked "Yes," describe that information and attach all documents to this application:

______

______

______

Total and Permanent Disability ("T&P") Benefits

A. Employment Information and Effective Date

1. Are you currently employed? [✓ Yes] ( ) No

If you checked yes, please complete the following:

Employer Self employed Job Title President
Employer's address P.O. Box 271506 Tpa FL 33688
Name of immediate supervisor ______ Phone number of supervisor ______

If you checked no, please complete the following:

Last date of employment ______ Employer ______ Job Title ______
Employer's address ______
Name and phone number of immediate supervisor ______
Reason for leaving ______
Job description and responsibilities ______

2. Do you seek retroactive T&P benefits (benefits for periods before you are examined by a physician selected by the Plan)? ( ) Yes [✓ No]

If you checked "No," skip to Section B "Disabilities and Cause". If you checked "Yes," provide the earliest date you believe you became unable to work and complete the rest of this Section A: ______

The date you indicated on the prior line is your "Requested Effective Date." Describe why you chose this date:

______

______

______

3. The Plan does not provide T&P benefits for periods more than 42 months before your application is received by the Plan Office, unless you are found to have been mentally or physically incapacitated in a manner that substantially interfered with the filing of this application. If you seek such an exception to this 42-month rule, list below or on an additional sheet all reasons for which you claim an exception:

______

______

______

4. Employment History

Please complete the following for each job that you have held from your Requested Effective Date to the present:

Last Employer ______________ Job Title ______________ Dates of employment ______________
Job Description/Responsibilities ______________
Employer's address ______________
Name of immediate supervisor ______________ Phone number of supervisor ______________
Reason for leaving (i.e., why you quit or were fired) ______________

Prior Employer ______________ Job Title ______________ Dates of employment ______________
Job Description/Responsibilities ______________
Employer's address ______________
Name of immediate supervisor ______________ Phone number of supervisor ______________
Reason for leaving (i.e., why you quit or were fired) ______________

Prior Employer ______________ Job Title ______________ Dates of employment ______________
Job Description/Responsibilities ______________
Employer's address ______________
Name of immediate supervisor ______________ Phone number of supervisor ______________
Reason for leaving (i.e., why you quit or were fired) ______________

Prior Employer ______________ Job Title ______________ Dates of employment ______________
Job Description/Responsibilities ______________
Employer's address ______________
Name of immediate supervisor ______________ Phone number of supervisor ______________
Reason for leaving (i.e., why you quit or were fired) ______________
(Attach additional sheets if necessary)

5. Tax Returns

You are requesting a retroactive effective date for total and permanent disability benefits. Therefore, enclose with this application complete copies of all federal income tax returns for the year before your Requested Effective Date through the present. These complete copies must include all schedules and related forms, such as W-2 forms. If you do not have copies of any of these forms or if you did not file a federal tax return for any of these years, you must request copies of your tax returns or verification of non-filing from the IRS using Form 4506 (copy attached). Since you are requesting retroactive total and permanent disability benefits, your application will not be complete and will not be considered by the Plan until the Plan Office receives all of these federal income tax returns. Please note that tax returns for this and later periods may be requested periodically by the Retirement Board.

6. Social Security Earnings Statement

If your Requested Effective Date is more than one year prior to the date of this application, you must enclose (or forward later to the Plan Office) a current copy of your detailed Social Security earnings history. Use Form SSA-7050 (copy attached) to request this detailed earnings history.

7. Medical and Hospital Records

Enclose, with this application, complete copies of all medical and hospital records for all years for which benefits are claimed. You may get a copy of these records by asking your providers (that is, physicians, hospitals, etc. that have treated you) for your records.

B. Disabilities and Cause

1. Describe all of the conditions that you believe make you unable to work. Please indicate for each:

   A. The type or types of doctors you have seen because of this condition. (For example, orthopedist, cardiologist, neurologist, psychiatrist, internist, oncologist, endocrinologist, ear nose and throat, opthalmologist, gastroenterologist, urologist, dermatologist.) Write "None" if you have not seen a doctor for this condition.

   B. Whether you believe this condition resulted from NFL Football activity, from service in the military of any country, or from other causes.

C. Describe this condition, and explain how it prevents you from working. If you believe this condition resulted from NFL Football activity, also describe how NFL activity caused this condition.

You may attach additional sheets if you require more space.

Condition 1:

Physician Types: orthopedic

Cause of Condition [✓ NFL Football] ( ) Military Service ( ) Other

Description: I have unfortunately cervical spondylosis with upper extremity radicular symptoms referred to as radiculopathy. I am unable to sit for more than 10 minutes without having to stand. I am unable to stand for no more than 5 minutes without having to sit.

Condition 2:

Physician Types: orthopedist

Cause of Condition [✓ NFL Football] ( ) Military Service ( ) Other

Description: I unfortunately have significant spondylosis lumbar spondylosis with facet arthropathy at multiple levels & lower extremity radiculopathy. I am unable to complete a work day because of having to constant alternate between sitting & standing every few minutes to relieve the pain. I herniated my lumbar in my last NFL game.

Condition 3:

Physician Types: orthopedist

Cause of Condition [✓ NFL Football] ( ) Military Service ( ) Other

Description: I unfortunately have degenerative joint disease chondromalacia & osteochondral defect of the humeral and osteochondral defect of the humeral and osteochondral defect of the glenoid rim and degenerative tears of the glenoid. I am schedule to begin pain management consultation next week. (I) I landed on my shoulder & was never told that it was cracked by team doctors.

Condition 4:

Physician Types: Orthopedist

Cause of Condition ( ) NFL Football ( ) Military Service ( ) Other

Description: I have chondromalacia patella in both knees, I am unable to sit for more than 10 minutes without having to stand up to relieve the pain. I also cannot stand for more than 10 minutes because of the pain. I am to begin pain management consultation to include facet injection & associated trigger points and neural foraminal injection.

(Attach additional sheet if necessary.)

2. Describe all accidents, injuries, or illnesses that did not result from NFL Football (for example, auto accidents) and that may have caused or contributed in any way to any of the above conditions: All injuries were the direct result of pro football unfortunately.

3. Please note that special rules apply where a condition relates to alcohol or substance abuse, or to psychiatric problems. In general, if such conditions are the cause of your inability to work, they will automatically be considered to not result from NFL Football activities. Certain exceptions apply, as described at the end of this form. If you believe you qualify for one of these exceptions, please describe and enclose all supporting documentation.

C. Attending Physicians

Please list the names of your treating physicians for each of the conditions described in Part B above. You should not list the names of your team physicians or physicians that the Plan has referred you to. You may attach additional sheets if you require more space.

Name of Physician Dr Janecki Condition for which seen Back, knee, neck
Dates of Treatment 4 times in 1993 — 99-2002-03 Approximate number or frequency of office visits 10
Physician's Address and Phone Number 1011 N MacDill Ave Tpa FL 33607 813 870-2900

Name of Physician Dr Shapiro Condition for which seen Severe Back Pains
Dates of Treatment 89 - 90 - 93 - 2000 Approximate number or frequency of office visits 25
Physician's Address and Phone Number C 13301 Orangegrove Dr Tpa Fla 33618
813-960-83[illegible]

Name of Physician Dr Richard Shaker Condition for which seen Back / neck - knee - shoulder
Dates of Treatment 99 - 2000 - 2001-2002-03 Approximate number or frequency of office visits 75
Physician's Address and Phone Number Henderson Point Building 2314 Henderson Blvd #203

Name of Physician Dr Alfred Bonati Condition for which seen Knees / shoulder / Back
Dates of Treatment 90-91-92-93-94 Approximate number or frequency of office visits 50
Physician's Address and Phone Number 7315 Hudson Ave Fla 34667

Name of Physician Dr Parson Condition for which seen Knee / Back
Dates of Treatment 89 - 90 - 92 - 93 Approximate number or frequency of office visits 10
Physician's Address and Phone Number 3006 West Azeele St.

Name of Physician Dr [illegible] Condition for which seen knee Back shoulder
Dates of Treatment 88 - 89 - 93 Approximate number or frequency of office visits 10
Physician's Address and Phone Number Sports & Orthopedic Physical Therapy specialist
2810 Camino del Rio #2003 SD CA 92108

D. Other Information

Do you wish to provide additional information in support of your application for T&P benefits? You are encouraged to provide any information you believe will be helpful to the consideration of your application.

(✓) Yes ( ) No

If you checked "Yes," describe that information and attach all documents to this application:
(1) Information to support that I was an active player when Injury occurred. (2) medical records of Injuries & the degenerative changes that has occurred from 87-2003.

Worker's Compensation/Social Security Disability Information

Have you ever applied for Workers' Compensation? [✓ Yes] ○ No

What was the result of your application?
[✓ Benefits Awarded]
○ Benefits Denied
○ Application Pending
Attach copy of decision, if benefits were awarded or denied.

If you were awarded Workers' Compensation benefits, how much is the benefit and in what form is it paid 39,000 1996

Workers' Compensation Claim No. see attachment 1349736 137758 State CA

Have you ever applied for Social Security Disability Benefits?
○ Yes [✓ No]

If you have not applied for Social Security Disability Benefits, you may wish to consider doing so.

What was the result of your application?
○ Benefits Awarded
○ Benefits Denied
○ Application Pending
Attach copy of decision, if benefits were awarded or denied.

If you were awarded Social Security Disability Benefits, how much is the monthly benefit?________

Social Security Claim No.________

Have you ever applied for disability benefits from your current employer or from any prior employer?
○ Yes [✓ No]

What was the result of your application?
○ Benefits Awarded
○ Benefits Denied
○ Application Pending
Attach copy of decision, if benefits were awarded or denied.

If you have received or have ever been awarded disability benefits by any employer, how much is or was the benefit and in what form is or was it paid?________

I hereby apply for disability benefits from the Plan. I certify that all the information provided on or with this application is, to the best of my knowledge, true, correct, and complete. I certify that any and all documents or information attached to or enclosed with this application are, to the best of my knowledge, true, correct, and complete. I recognize that I may be subject to loss of benefits and to other penalties and sanctions under law if I have made any false or misleading statements or omissions.

Player's Signature ________ **Date** 9-13-03

Authorization for Use or Disclosure of Individually Identifiable Health Information

In connection with your application for disability benefits, you may submit, or have submitted on your behalf, individually identifiable health information, including your disability application, medical records, and physician reports. You also may be referred to Plan neutral physicians or Medical Advisory Physicians for medical examinations, and these physicians may submit health information to the Plan on your behalf. The Plan has contracted with Intracorp, a provider of independent medical examination services, to coordinate such examinations. The Plan or its agents may disclose your health information to Intracorp personnel, physicians affiliated with Intracorp, and other individuals associated with the Plan.

Please sign below to indicate your authorization for the Plan or its agents to use or disclose your health information for Plan purposes.

I hereby authorize the Bert Bell/Pete Rozelle NFL Player Retirement Plan to use or disclose all individually identifiable health information submitted to the Plan on my behalf, or created in connection with my application for disability benefits, to all individuals as needed for Plan purposes.

Player's Signature ________ **Date** 9-13-03